# VETERANS' ADMINISTRATION HEALTH CARE IN WEST VIRGINIA

## HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

## COMMITTEE ON VETERANS' AFFAIRS
## HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

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# VETERANS' ADMINISTRATION HEALTH CARE IN WEST VIRGINIA

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**MONDAY, MARCH 19, 1984**

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
*Washington, DC.*

The subcommittee met, pursuant to notice, at 9:49 a.m., at the Veterans' Administration Medical Center, Martinsburg, WV, Hon. Bob Edgar presiding.

Present: Representatives Edgar, Staggers, and Mollohan.

## OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. EDGAR. The Subcommittee on Hospitals and Health Care will come to order. I'm Congressman Bob Edgar from beautiful downtown Delaware County, PA, south of Philadelphia. I've been a Member of Congress for the last 10 years. I serve on the House Veterans' Affairs Committee with my colleagues Congressman Staggers and Congressman Mollohan. I chair the Subcommittee on Hospitals and Health Care, and it is a privilege and a pleasure to be here today, to have a chance to view this particular hospital facility as well as look at other health care facilities for veterans in the State of West Virginia.

I'm going to read a very brief opening statement. I'm going to yield to my colleagues for opening statements, and then we'll move right to our first set of witnesses and hear from the hospital director and medical staff here, and from the veterans' organizations. If time permits we'll have an open mike, and veterans or others who would like to provide a statement for the record or ask a question or make a comment at the end may do so.

This is the subcommittee's first oversight field hearing for this year. I wish to welcome each of you to this hearing to review Veterans' Administration inpatient and outpatient health care delivery here in West Virginia. I am pleased to be here in the beautiful State of West Virginia, and I thank my good friends and colleagues, Harley Staggers and Alan Mollohan, for inviting me and the subcommittee to be here today. Both Harley and Alan are active and productive members of our subcommittee. They have expressed great concern for our Nation's veterans and the services and benefits they have earned. I know they are very concerned with the quality and quantity of health care delivered by the VA Hospitals in West Virginia, especially in Martinsburg and Clarksburg.

Earlier today we toured this VA medical center and following the hearing, we will fly over to Clarksburg to look at the facility and conduct a hearing there.

Last year, this subcommittee held oversight hearings into the quality and quantity of health care delivered by the VA in the six medical regions which make up the VA's health care system across the country. We went to western Pennsylvania, Chicago, Boston, Colorado, California, and Florida. During those hearings we became aware of many outstanding medical services being provided to our Nation's veterans. We also learned of several problems which inhibit the VA's health care professionals in providing quality, as well as quantity care. We are interested over the next several years in looking at ways in which we can address the problems that we discovered.

Most of the remedies to correct these problems require additional funding. This is especially true in the delivery of ambulatory or outpatient care. We are aware that most medical centers are offering non-service-connected care only to the extent that funds are available, rather than to a level sufficient to meet the needs of all eligible veterans. Substantial new resources and staffing, as well as some redistribution of funding on a nationwide basis by the VA central office, will be required to remedy this significant problem.

To provide some help with this problem, last week during the committee's markup of the fiscal year 1985 budget, I recommended a transfer of $50 million from the VA's construction working reserve to the medical care account which will provide 1,000 additional staff for outpatient services. I am pleased that both Congressmen Staggers and Mollohan strongly supported my recommendation and that the full committee also approved of it in our report to the Committee on the Budget.

In this report, we recommended a total of $27.6 billion for veterans' benefits and services, including $9.1 billion in medical care funds. This is an increase of approximately $600 million for the medical account. My other budget recommendations included an increase in funding of $14.4 million and 190 employees for extended care services; $13.9 million and 21 employees for high tech equipment such as CAT scanners and PET scanners, as well as an authorization for 220 additional staff in the vet center program.

One of the important purposes of our field hearings is to learn how the medical center directors are planning for the significant increases in demand for health care caused by the aging veteran population. Nationwide, the VA estimates that the demand placed on the medical system due to increasing numbers of aging veterans will triple in the next 10 years. By 1990 alone, more than one-half of all American men over age 65 will be veterans. This rapidly aging population not only places a heavy demand on the VA for nursing home care, but also hospital care resulting from acute episodes of chronic illness. We must cope with the present demand. However, we must also be prepared to accommodate the future demand on the system as well.

For the past 2 years, the Veterans' Administration's Department of Medicine and Surgery has been in the process of developing a new planning methodology called Medical District Initiated Program Planning. This planning process employs a decentralized pop-

ulation based planning methodology approved by the Office of Management and Budget and the General Accounting Office which involves medical districts in planning for future health care requirements based on projections of eligible veterans. This highly efficient and accurate system is used nationwide to determine VA health care requirements and is used extensively in development of future bed needs for West Virginia.

We will be asking some questions relative to this plan for the future of the veterans' health care system this morning.

We really look forward to this hearing and learning the results of this planning process for the future of the medical center.

I'd like to recognize the fact that on our panel this morning are also our counsels, Jack McDonell and Pat Ryan. Both these gentlemen are on the staff of the House Veterans' Affairs Committee and are here to help us with the technical aspects of the hearing.

I'd now like to recognize Hon. Harley Staggers for any remarks he wishes to make at this time.

**OPENING STATEMENT OF HON. HARLEY O. STAGGERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA**

Mr. STAGGERS. Mr. Chairman, I would like to take this opportunity to thank you for holding this hearing in West Virginia; particularly here in Martinsburg and Clarksburg. I would also like to thank my colleague, Alan Mollohan, for participating in the hearing today.

I know that both of you are very hard working, concerned members of the committee and I compliment the leadership that you've taken with the committee, especially in concern for aging veterans and Vietnam veterans. I'd also like to thank the people who are here today from the different veterans' organizations.

In particular, I'd like to compliment Mr. Billes for the concern that he's shown. I've been in contact with him over various concerns. I want to compliment the staff that he's assembled at the VA facility here in Martinsburg.

I want to point out that in December, when I toured the VA center, I told Mr. Billes that I would try to bring the subcommittee here to see this facility that we are proud of, and to point out that we do get our money's worth when we spend Federal dollars on veterans here in Martinsburg.

This is not to ignore that we do have problems. No matter how good the staff can be, no matter how well you select your people, you are going to have problems. And the problems that I can identify here in Martinsburg basically boil down to budgetary-type problems.

Some of the problems that I mentioned earlier and the subcommittee chairman, Mr. Edgar, mentioned also dealing with the aging veterans, are ones that we need to be concerned with. Also the Vietnam veterans that have been ignored for so long are starting to gain the recognition that they deserve.

One particular problem which I wanted to make the subcommittee aware of, and I'm sure my colleague, Mr. Mollohan, would also agree with this, is the fact of the service that the VA can render to

rural America. Our problems are somewhat different, we serve a very large area. Sometimes the problems are different and go unrecognized in some urban areas. So the fact that we can address these problems, I think, is a very large step forward. I would once again compliment the chairman and compliment the people who are here.

Mr. EDGAR. Thank you. Mr. Mollohan.

**OPENING STATEMENT OF HON. ALAN B. MOLLOHAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA**

Mr. MOLLOHAN. Thank you, Mr. Chairman. I, too, appreciate the opportunity to be here and thank the chairman for his willingness to hold these hearings in West Virginia—both in Martinsburg and Clarksburg later on this afternoon. That reflects a commitment to look at veterans' services all over the country. As a member of the committee, along with my good colleague and friend Congressman Staggers, we're very interested in what happens to our West Virginia veterans. We appreciate your spending a whole day in West Virginia, and we understand what kind of a commitment that is. We really appreciate it.

I would like to say what a pleasure it has been to work on a committee with you and also with Bucky because I know his interest. Together we have been, I think, very effective in regard to veterans' programs.

I want to express my appreciation to the staff this morning for a good briefing and a good prep. I look forward to the kind of information that you're going to bring to this hearing to give us a better appreciation of what kind of needs there are as you deliver these health care services to our veterans. I'm also looking forward to hearing from the veterans' associations. There's no better source of information, I've learned in my 1 year in the Congress, than the veterans' organizations to understand how we can connect up in the best sort of way the delivery with receiving services.

I'm very pleased to be here and look forward to the kind of information that's going to develop in this hearing. Thank you, Mr. Chairman.

Mr. EDGAR. Before we begin our hearing, let me just say for those of you who are unaware of the size and scope of the veteran's health care system, that there are 172 veterans' hospitals, 226 outpatient clinics across the country and some 135 Vietnam veterans' readjustment counseling centers across the country. Last year we visited over 20 different hospitals. This State is to be commended. You have two very active members of the House Veterans' Affairs Committee, and I can tell you that we probably wouldn't be here if they were not on that particular subcommittee because the demands on the Chair of this particular subcommittee are great. But I think that, as Mr. Staggers has indicated, it's really important for someone like myself who comes from urban America, to come out into rural America and see the difference and uniqueness of VA facilities in this type of setting.

I was telling Mr. Mollohan on the way over from the hotel this morning that my district is 14 miles across from border to border,

and 520,000 people live in my very congested urban suburb. The conditions, the needs, the kinds of problems that kind of a community faces is far different than the kinds of concern that we've begun to feel and sense just by being in this area. So I want to commend the State of West Virginia, not only for electing these two individuals, but for having the good sense to encourage them to be on the House Veterans' Affairs Committee. I figured it out that it will only take them about 15 years to become Chair of the House Veterans' Affairs Committee and Chair of this subcommittee, because there are some young men who sit on the other side of them—young men and women—but they will play an active role over the next few years in making sure that the financial resources are adequate to meet the needs of the four veterans' hospitals in West Virginia as well as West Virginia's many other needs.

Mr. MOLLOHAN. We don't want to move you out, Mr. Chairman, as good a job as you're doing.

Mr. EDGAR. I want to thank you for that. [Laughter.]

I want to now recognize the hospital director and ask that before you begin your statement, you identify for the record, those who are sitting at the table with you. I would also indicate to those at the table that we welcome your comments in addition to the statements of the director.

**STATEMENT OF I.V. BILLES, DIRECTOR, VA MEDICAL CENTER, MARTINSBURG, WV, ACCOMPANIED BY DR. SJORGEN, CHIEF OF STAFF, VA MEDICAL CENTER; MR. ASHBY, CHIEF OF ENGINEERING, VA MEDICAL CENTER; AND MR. DERONDA, CHIEF OF MEDICAL ADMINISTRATION, VA MEDICAL CENTER**

**STATEMENT OF I.V. BILLES**

Mr. BILLES. Mr. Chairman, Mr. Staggers, Mr. Mollohan, and staff. We're delighted that you are here today and representing the Subcommittee on Hospitals and Health Care of the Veterans' Affairs Committee. We share with you the importance of this hearing in understanding and appreciating some of the problems we might have and some of the successes.

I am privileged to have at the table with me, Dr. Sjorgen, our excellent acting chief of staff; Mr. Ashby, our chief of engineering; and Mr. Deronda, our chief of medical administration.

Just to provide some brief history of the institution and to give you some idea of how we function, this hospital was built in 1943 by the Army, it was taken over in 1946 by the VA. We now have a 414-bed hospital, a 120-bed nursing home and a 540-bed domiciliary. The new hospital will have 357 beds and a 120-bed nursing home, 200 new domiciliary beds and we will continue to function or operate 340 beds in the old domiciliary buildings.

We're affiliated with Howard, Georgetown, and George Washington Universities; also the dental school of West Virginia University. Our catchment area consists of 23 counties: 8 in West Virginia, 8 in Virginia, 4 in Maryland, and 3 in Pennsylvania. The population in this catchment area is 118,000 veterans.

We have, as you have indicated, a different catchment area than what is usual for the urban hospital in terms of distance. Pendleton County in West Virginia is the furthermost reach at 160 miles

away. Franklin County in Pennsylvania is 105 miles. Garrett County in Maryland is 120, and Page County in Virginia is 110. This just gives you some idea of the distance that veterans might have to travel in order to avail themselves of the services that we provide.

In terms of the long-term care, we have a 120-bed nursing home and at the present we have 96 beds in the intermediate care section of our hospital. The new hospital will have a 120-bed nursing home and 80 beds of intermediate care. However, we are proposing to our central office that a 20-bed alcohol rehabilitation unit be placed in our domiciliary and these 20 beds be used for intermediate care purposes. Hopefully, this will be approved.

We have some 81 veterans in community nursing homes at VA expense as of this moment. We have a waiting list of 78 for our intermediate beds and 17 for our nursing home beds. The normal mix of patients recommended by our central office for nursing home care beds, are 30 percent categories I and II, and 70 percent categories III and IV.

Here, because we outplace the better of our patients and keep those that need the most care, we have in our nursing home 85 percent categories I and II and only 15 percent categories III and IV. In our new hospital, even though it has 57 fewer beds than what we have now, we will have 60 percent more space than what we have in the old facility.

Speaking of special programs, we have 39 Vietnam vets in the hospital as of Friday and 57 in the domiciliary. We have 100 Vietnam vets in our seven readjustment counseling centers over which we have administrative responsibility.

We have 6 female veterans in the hospital, 46 in the domiciliary, and 3 in the nursing home care unit.

We have done 701 agent orange exams, 33 POW exams, and 22 radiation exposure exams. We have no backlogs in any of these. We have no waiting lists in any of our hospital services except in the intermediate and long-term care area. To try to address some of the problems we see with the aging, with the ever increasing number of aging veterans, we have outplaced a number of these at Government expense and hope to create, certainly within this medical district, additional beds for long-term care patients.

Because of the crunch on our pharmacy within the last several months, we've added four pharmacists and six pharmacy technicians because we are going into the unit dose system even though we have not been funded in this area to cover the magnitude of additional staffing that will be required to accomplish this. These are some of the basic facts that we would like to make and now, if someone has some questions, we'd be happy to respond.

[The statement of Mr. Billes appears on p. 35.]

Mr. EDGAR. I'm going to yield to my colleague, Mr. Staggers, for first questions, and I have a shopping list of 500 or 600 questions to ask.

Mr. STAGGERS. Mr. Billes, although this was covered in the briefing this morning, there are some problem areas, especially with the construction of the new hospital. Could you outline this for us, for the record?

Mr. BILLES. Well, when the new hospital was being constructed because of, I guess it was inflation back then, the amount of money that was appropriated for the construction of the hospital, when we reached the fourth phase there were three major areas included in the planning that should be a part of the replacement facility that were left out because of lack of funds.

These were: one elevator, the finishing off of a research space, and the construction of a water filtration plant. All of these were left out with the proviso that we would submit projects for their inclusion and construction at a later time. Meanwhile, Public Law 98–45 came into being and some of the plans we had for the elevator and for the other facilities that we were planning on could not be accomplished in a timely fashion. That now has been programmed to be accomplished within 1 year after we have activated the hospital, this is especially true of the new elevator.

Mr. STAGGERS. Also, it was mentioned about a structural defect. Would this be the best way to characterize the roof.

Mr. BILLES. The roof?

Mr. STAGGERS. Yes.

Mr. BILLES. Oh, to the nursing home and domiciliary. This has been an ongoing problem, the leaking of the roof. We have made the situation known to the resident engineer, who is representing the office of construction here, and corrective action has been taken in many cases. In some cases we still have some leaks, but the indications are that the warranty has run out and it's going to be the responsibility of the station to correct those situations where this has occurred.

Mr. STAGGERS. But the contractor is still here on site, am I not correct?

Mr. BILLES. Yes, sir.

Mr. STAGGERS. And to replace that roof there was an estimate of $100,000, to replace not the whole roof, but the trouble spots?

Mr. BILLES. This was the figure that the engineering officer provided this morning, and this is an estimate of what it would cost.

Mr. STAGGERS. And with the elevator and the research room, will that be needed in the future or could you anticipate needing that in the future?

Mr. BILLES. Yes. And we have in place, asked for these facilities and we have had reassurance that the supply and engineering space is on the second floor that will both take part of the space where research was to have been, that this will be done as a completion item, and hopefully it will be accomplished in a timely fashion. It will be a great help to us in giving some much needed space for administrative purposes.

Mr. STAGGERS. Switching tracks again, what's the present status of your recruiting and retention of registered nurses here at the facility?

Mr. BILLES. We are in the very enviable position of being able to recruit nurses. We have not had a shortage and we can recruit as many nurses as we have vacancies and resources to bring onboard.

Mr. STAGGERS. Is that because of the nursing schools in the area?

Mr. BILLES. Generally that is the situation. We have a large number of applicants of nurses who come from cities and other places because they would rather be here than some of the other

hospitals where they might be working. We do get a number of applications from your metropolitan areas as well as from the local areas nearby.

Mr. EDGAR. Will the gentleman yield?

Mr. STAGGERS. I yield to the chairman.

Mr. EDGAR. Do you have your chief of nurses here?

Mr. BILLES. Yes.

Mr. EDGAR. Could he or she be recognized?

I just thought maybe if she is available, or he, it would help us to ask that same question.

Also in terms of recruitment and retention, what are some of the incentives that you use in recruitment, or what kinds of tools could you use in recruitment, education tools or other financial inducements?

Mr. BILLES. Our greatest difficulty in recruiting is in about three areas: one is in physician specialities. Particularly this would be in an area like orthopedic surgery where we have had a vacancy for several years that we have not been able to fill. However, we have done very well by using consultants from the local community.

The other areas is in full-time, part-time; these are the areas where we have the most difficulty recruiting. We have not offered too much incentive other than the fact of being employed by a very fine institution where all of our resources in this community are geared toward providing the best possible care, and I'm sure this is something that is positive.

Mr. STAGGERS. If I may reclaim my time.

Mr. EDGAR. Yes. Thank you for the time.

Mr. STAGGERS. One problem that I have, because there is a large pool of nurses, is the subtle threat—whether it stems from your staff or from the fact that there are a lot of people out there who would like to work here at the VA. There appears to be, and I've spoken to some of the nurses here at the facility, an inconsistency in the granting of pay increases. I understand that this may come from the central office.

One problem that I'm becoming aware of is that it may be a budgetary problem. There has been the suggestion to some of the nurses that, in fact, West Virginia doesn't need qualified nurses; even though these nurses are qualified and they are working here at the hospital now.

To upgrade that, they can't make that justification across the board. I understand that with the new regulations that out of 150, 143 did not receive raises.

Could you address that problem for me?

Mr. BILLES. We have a professional board that review the qualifications of nurses and they are required under the regulation to determine what is being performed by the nurse as well as compare this to the set standard in order to justify the promotions.

I have had several nurses come to me with the concern that they had not been favorably considered even though they felt they met all of the qualifications.

I have advised them, in every instance, that they should appeal any action taken by our board to the central office. If they meet the qualification standards our board work will be reviewed by the central office board and where promotion is approved by central

office we would certainly comply. And this is just an interpretation as to what is required by the standard and what is being performed by the nurses themselves.

Mr. STAGGERS. My concern would be, being a lawyer by trade, that in an administrative hearing if the steps have been followed, you have no real appeal.

I guess my concern would be: Are the regulations being applied across the board and across the Nation in other VA facilities? If you are a nurse at this facility and you have this qualification, can you, in fact, look at another VA facility and see that they are promoting and this facility is not?

And that's my concern about the budgetary problems: Are we in fact being discriminated against here in West Virginia?

Mr. BILLES. So far as I'm aware the answer would be no. But I don't know what is really happening in most of the other areas. But it's not our policy to, in any way, discriminate against any of our employees who meet the criteria and who are performing at the level required.

As I say, I've advised everyone who would have any sort of complaint to certainly appeal. This is an area where the central office board would get a cross-section view of what the record shows as opposed to what any individual hospital board might say or do.

Mr. EDGAR. Would the gentleman yield?

Mr. STAGGERS. I yield to the chairman.

Mr. EDGAR. I would like to ask the question of comparison salaries between nurses in this facility and nurses in the community hospitals.

Mr. BILLES. Yes. Our salaries, as I understand it, are higher than those in the surrounding community hospitals.

We have four hospitals in the immediate area or five, that is the City Hospital, Berkeley Springs, Jefferson County, Washington County in Hagerstown, MD, and in Winchester.

Our salaries are generally higher than those in those facilities.

Mr. EDGAR. Thank you very much.

Mr. STAGGERS. If I could reclaim my time again.

Can you give me a comparison between the nurses salaries and, say , the housekeeping and some of the other employees at the hospital?

Mr. BILLES. The journeyman level now, the nurse is a GS–9, I believe, and a building management journeyman level employee is WB–2 with a salary somewhere in the range of $15,000 and $16,000.

The nurse certainly is at a higher level than building management. At the journeyman level of GS–9, that would be $20,965 as beginning. You usually speak of a salary at about the fourth step which would be at $23,000 for the journeyman level as we have it here.

Mr. STAGGERS. I don't want to get away from my point. The question that I want to ask is, in fact: Are the regulations that have just come into place being interpreted in each VA facility the same way?

Is there an across-the-board type of interpretation of those new regs or is Martinsburg being able to interpret it in a different way?

Has the central board made a uniform interpretation of the regulations?

Mr. BILLES. In every instance where anyone feels that there is a different interpretation being provided here as opposed to any other place, we welcome their letting us know.

It is our policy, certainly, to be as conscientious about this and as liberal as we can be and yet we do have a responsibility of interpreting the regulation and the standard in a very objective way.

Mr. STAGGERS. Mr. Chairman, when the chief of nurses comes out, I would request that I be allowed to ask the same question. I accept your answer, but I don't think it really answers my question.

Mr. BILLES. OK.

Mr. STAGGERS. One last question, Mr. Chairman, and this is another concern of mine. It basically deals with the Outreach Program that Congress had mandated for Vietnam veterans.

My question would be: How are you treating veterans suffering from post-traumatic stress disorder within this area? This question might be better addressed to the chief of the medical staff.

Dr. SJOGREN. Well, we do see a number of patients with post-traumatic-stress syndrome. A number of patients who perceive that they have it, and these are all referred to the psychiatry department here.

Mr. STAGGERS. In the prepared statement by Mr. Billes there is a reference to contracting out with private firms for counseling for both jobs and career.

I'm aware of the Morgantown facility, which is a very good facility. But if you are a Vietnam veteran here in Martinsburg, where would you go? Are you aware of how those veterans are receiving the care that they should be receiving?

Mr. BILLES. We have seven such centers and initially, under the contract we had some reservations about how it was really functioning.

We had an audit made of all of the centers to determine just how well they were functioning. And we've just recently completed a review of all of these and it is my understanding now that we are in full compliance and doing a very fine job.

There were some question before about the effectiveness because of some of the looseness of the contract language itself.

Mr. EDGAR. If the gentleman would yield.

Mr. STAGGERS. I yield.

Mr. EDGAR. We're having some problems nationally with the whole concept of contracting out psychiatric care and post-traumatic-stress disorder. We have some very good contractors and we have some ripoff artists, and that's the reason for the question.

Is there a contractor in this general area who deals with those Vietnam veterans who have particular problems relating to jobs, or rehabilitation counseling, or post-traumatic-stress disorder?

Mr. BILLES. We do have contractors dealing with these and this is specific to those Vietnam veterans who have indicated they may not want to come to this hospital for treatment. And these were the hundred I indicated earlier that are in seven readjustment counseling centers.

Mr. EDGAR. Can you tell us where there are located?

Mr. BILLES. There is one in Hagerstown, Winchester, Leesburg, Parkersburg, Fairville, PA.; Cumberland, MD. These are some of the locations where we've had them. Petersburg, WV.

Mr. EDGAR. Thank you.

Mr. STAGGERS. If you can indulge me one more question, Mr. Chairman?

Mr. EDGAR. I yield the gentleman one additional question.

Mr. STAGGERS. I apologize for taking a lot of time.

There is one other concern that I have and that is with the ever-increasing age of veterans, as our chairman has pointed out. Can you outline, generally, the steps that are being taken to accommodate the aging veterans here in West Virginia, particularly with the area that you're covering?

Mr. BILLES. One of the things that we're doing just now, as I said, we presently have a 96-bed intermediate care section in our present hospital of 414 beds.

In the new 357-bed hospital there with be only 80 such beds. We are proposing to our central office that the 20 beds for the alcohol rehabilitation unit be used for the intermediate care of patients.

I'm aware that there is, in this medical district, and our medical district is made up of Washington, DC; Lockraven VA hospital in Baltimore, MD; Perry Point, MD; and Fort Howard, MD. There is the recommendation to have a 120-bed nursing home unit somewhere in the Baltimore area. There's a 120-bed nursing home unit under construction now in Washington, DC.

We have indicated that an option for this station would be to take at least 100 beds of the new domiciling unit and to convert them to nursing home beds. And we could care for the domiciliary patients in some of the existing older buildings where we now have 340 domiciliary beds.

This would provide additional resources for taking care of the elderly patient at a very minimal cost.

Mr. EDGAR. I would like to, at this time, yield additional time to my colleague for pursuing questions that he was raising with the nursing director.

Dr. SJOGREN. This is Ms. Pauline Rohall, our chief nurse.

Mr. STAGGERS. Ms. Rohall, I had asked questions concerning what appears to be some inconsistency in granting of pay increases. I've talked to some of the nurses, and I'm concerned about some of the allegations such as the one that there's been a determination that we don't need qualified nurses in West Virginia.

Even though these nurses are now qualified and are working here, the budgetary aspect of it is we can't justify spending more money in West Virginia.

My concern is, has the central office interpreted the new regulations so that they are being applied across the board?

Ms. ROHALL. I feel that central office has given us some guidelines in the interpretation of these standards. I feel that we have treated everybody equitably.

Every nurse has the option of applying for a reconsideration of her promotion here at this institution. If she is not satisfied with the outcome, she has the option of going into the central office and being reconsidered there.

Mr. STAGGERS. And so with the centralized office there are objective standards. It's not going to be that there are some subjective standards that have been placed within this hospital?

Ms. ROHALL. When I came here I wrote some guidelines based on information that was submitted to me by central office. When I came here it was felt that we had nothing to give our people as to what was expected of them and how these guidelines would be interpreted.

We wrote these out, and we saw that this information was put forth to all of our nursing personnel. I do feel that everybody knows what is expected of them, and that they can work to get their promotions.

Mr. STAGGERS. Thank you. I want to compliment the staff here at the VA center, again. I think that you're doing a wonderful job. I am aware of some of the problems. It does concern me about the nurses when you have a large number of nurses who are not promoted. Just on the face of it, it does appear to be a problem.

I want to thank the chairman for allowing me this much time.

Mr. EDGAR. It's OK.

I yield to my colleague, Mr. Mollohan.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

I would like to explore a bit the nursing home facility. You apparently have a good one, and I'd like to understand it better.

What is the current elderly population in your district? And this is district?

Mr. BILLES. We're in district 6.

Mr. MOLLOHAN. What is the current elderly population in this district?

Mr. EDGAR. Mr. Deronda.

Mr. MOLLOHAN. Veterans.

Mr. DERONDA. I don't know the elderly population. I can tell you that 30 percent of our admissions to this medical center are 65 years or older. And this has been our trend for the past 3 fiscal years.

Mr. MOLLOHAN. Do you feel growing pressure for capacity to take care of aging veterans?

Mr. DERONDA. Each year the number of applications for admission to the hospital goes up for those veterans who are over 65.

Mr. MOLLOHAN. How do you measure that?

Mr. DERONDA. How do we measure it here?

Mr. MOLLOHAN. Yes, how do you measure need? How do you measure the increase and then the need and then your capacity to take care of the need?

Well, you have so many applications——

Mr. DERONDA. Need for care is a medical determination. I would like to say that we have an acceptancy rate here at this medical center of approximately 86 percent.

Mr. MOLLOHAN. Acceptance rate?

Mr. DERONDA. Eighty-six out of one hundred of our applicants are cared for, either as an inpatient or on one of our outpatient rolls.

Mr. MOLLOHAN. And how do you place those people?

Mr. DERONDA. That's a medical determination.

Mr. MOLLOHAN. Right. And who goes where?

Mr. DERONDA. The physician determines the type of care needed by the veteran based on his or her condition—at the time of application. A determination is made as to whether he could be treated as an inpatient or whether he could be treated as an outpatient.

Mr. MOLLOHAN. Those veterans coming to you who need nursing home care, how are you placing them? Say if you take 100, what percentage are going where?

Mr. BILLES. Of the patients needing nursing home or intermediate care, this is where we have a waiting list. That waiting list is for intermediate care and 17 for nursing home care.

Now, when we get an application and we don't have an available bed, they're placed on a waiting list. Anytime any of these patients, however, have an acute episode or an acute illness they are admitted immediately to the acute side of the hospital.

If the need is for intermediate care or for nursing home care, we do not have the beds necessary to accommodate them.

Mr. MOLLOHAN. I'm just trying to get an understanding of what is the need in the nursing home care area, how you're fulfilling that need, and to what extent you're unable to fulfill that need and what we ought to be looking to for the future.

So if you get 100 veterans who apply for nursing—or senior veterans who need some kind of treatment, what do you do with them and then who do you have left over, and what is the need that's left over?

Mr. BILLES. Well, what we try to do is to have as great a turnover as we can possibly get within the hospital to accept additional patients when they apply.

This includes the 81 I mentioned that we have out in community nursing homes, as of this morning, at VA expense. When we have an aging veteran that we can outplace in the community nursing home, this leaves a bed open for another veteran to be admitted to the hospital.

One of the situations that must be considered in the process is that if a veteran is service-connected for the condition for which he needs nursing home care, we can admit that patient directly to the community nursing home if he or she so desires.

If they're non-service-connected, they have to be admitted to the hospital before they can be outplaced. And this is what causes the problem with our having a long waiting list.

Mr. MOLLOHAN. OK. I need some numbers.

Mr. BILLES. OK.

Mr. MOLLOHAN. Tell me the different categories in which you would place aging veterans.

Mr. BILLES. One would be ambulatory care, another place where we would place them.

Mr. MOLLOHAN. Well, can you just tick them off for me? One's nursing home, isn't it?

Mr. BILLES. Yes; nursing home, intermediate care, community nursing home care, ambulatory care, personal care homes, and our own hospital. And if we could find a bed someplace else, we refer them, if they're closer to some other VA hospital, we try to get them into some other VA hospital.

Mr. MOLLOHAN. Now, with regard to all of those placements, are you at capacity in each? Are you filled up in all of them?

Mr. BILLES. Yes.

Mr. MOLLOHAN. And what overflow do you have and where does it exist?

Mr. BILLES. We have now a waiting list of persons who have applied here who would like to be in this hospital under one of those capacities, 78 in our intermediate care, and 17 for our nursing home care unit. That's at this time. That amounts to 95 people.

Mr. MOLLOHAN. All right. Is that a growing list? Are those growing lists?

Mr. BILLES. Yes. Constantly.

Mr. MOLLOHAN. And what do you project—right now, what percentage of your veterans population is aged? However you measure that.

Mr. BILLES. The figure that I have is a gross one for all veterans. I understand that at this time we have in excess of 3 million——

Mr. MOLLOHAN. Do you know what percentage of your veterans are senior veterans? That's just the one——

Mr. BILLES. What was the figure you gave?

Dr. SJOGREN. I gave—on our admission, veterans at 65 and over, we're running approximately 30 percent.

Mr. MOLLOHAN. And do you have a projection of how that's to grow in the next 5 to 10 years?

Mr. BILLES. According to gross figures it will triple by the year 1990.

Mr. MOLLOHAN. OK. That's what—6 years away?

Mr. BILLES. Yes.

Mr. MOLLOHAN. How do you intend to meet that demand, and are you planning for it?

Mr. BILLES. We have made some suggestions to our central office as to how we could address this.

Mr. MOLLOHAN. What are those suggestions? The chairman's going to cut me off in a few minutes and the longer you talk, the less time I've got to talk—so you'll just have to tick them off for me.

Mr. BILLES. One of the things that we have done is to ask that the 100 beds in our new domiciliary be converted to nursing home care beds.

Mr. MOLLOHAN. Now, have you made a judgment that you're not going to need those 100 domiciliary beds?

Mr. BILLES. It isn't suggested that we don't need them, but we can care for those 100 veterans in the present domiciliary buildings over to this side.

Mr. MOLLOHAN. OK, but you are thinking about it?

Mr. BILLES. Yes, sir. The whole VA is thinking about it.

Mr. MOLLOHAN. Is this part of your MEDIPP planning?

Mr. BILLES. Yes.

Mr. MOLLOHAN. And are you getting the kind of responses from the VA folks that, gee, we have to start planning for this?

Mr. BILLES. Yes. It is a part of the MEDIPP process and this will be the first year where the construction and——

Mr. MOLLOHAN. Who on your staff deals with that, directly?

Mr. BILLES. This would be Mr. Deronda, Dr. Sjorgren; the chief nurse, and Ms. Griffin.

Mr. MOLLOHAN. Would it be fair for me to say that you see this as one of the major needs that the future is going to hold for veterans?

Mr. BILLES. It is the overriding need of the Veterans' Administration and the medical community.

Mr. MOLLOHAN. You know I have a figure here, I don't know if my statistics are accurate, but that the over 65 veterans in district 5—and that's the district I'm from and probably not too far different—but the over 65 veterans in 1981 were as much as 9.2 percent of the veterans population.

And in 1985, not too long away, it's going to be 16 percent, not quite doubling. It goes to 25 percent in 1990.

I was just wondering, on a local level, do you feel comfortable that you're going to be able to serve that need? And what are you doing to communicate that discomfort, I would think, with the national Veterans' Administration?

Mr. BILLES. We do feel that very acutely, and we have communicated what we consider to be a logical, reasonable solution on our part, the part that we could play in addressing those needs——

Mr. MOLLOHAN. And that's by increasing your capacity?

Mr. BILLES. That's right.

Mr. MOLLOHAN. I know we're going to get back around Mr. Chairman, and I don't want to take too much time, but that's an important area I want to understand.

Mr. EDGAR. Thank you. I'd like to draw your attention to the charts that you have at the end of your statement. The first one dealing with employment and funding.

In 1980, you indicate that you had 1,186 people employed.

Mr. BILLES. Yes.

Mr. EDGAR. I'm sorry. It's not in your packet. It's in a separate packet.

In 1980, you had 1,186; 1983 you had 1,152. How do you account for that decline given the fact that you've had a new nursing home facility placed here?

Mr. BILLES. Periodically you have some redistribution of resources within the district and within the region and we, I think it was in 1982, that we lost—through attrition, 69 positions.

In the new nursing home we were allocated 117 positions when it opened. And someone thought we were a little bit fat at the time so they took another 28 of that and distributed it over to Perry Point for a nursing home that was opened without any additional FTE.

So when you take the 117 we were allotted, and you take away the 69 plus the 28, it didn't leave us very many in connection with the opening up of the nursing home.

In the opening up of the new hospital, we were given 69 additional FTE that's available to us now in fiscal year 1984. Now this is to bring on additional people to take care of the additional needs that's in the new hospital.

As I've just pointed out, we have 60 percent more space in the new hospital than what we had in our old facility. The corridors are going to be much longer from nursing station to patient bedside. We provide greater privacy. We provide more bathrooms.

We have three times the number of face bowls over there than we have in the old one. We have five times the number of showers.

We have—and all this must be cleaned—60 percent more space—515,000 square feet over there, as opposed to 218,000 that we have over here.

So it's going to take much more FTE just to clean the place. Engineering has some very sophisticated, complicated systems going into that new place. And it's going to require a different caliber of person to look after that new building, as opposed to this one. And all of these are going to require additional resources.

But it's not nearly what it did require, but we hope to be able to take care of it.

Mr. EDGAR. Let me draw your attention to your prepared statement, the medical center profile that you have in the back.[1] Let me ask you to look down under outpatient workload.

Mr. DERONDA. Yes.

Mr. EDGAR. Could you explain the cause for the increase in the 1010 area from 5,919 to 10,058 in a period from 1980 to 1983.

Mr. DERONDA. Yes, sir. There was a redefinition of our application.

Mr. EDGAR. What's that?

Mr. DERONDA. There was not an increase or decrease in our outpatient workload. We were not counting as a 1010 application those veterans who were coming into the hospital that were on our outpatient rolls and being admitted for a condition other than which they were placed on the outpatient load.

Mr. EDGAR. Let me play dumb. I don't understand what you said.

Mr. DERONDA. As an example, if I were to come into this hospital and I was being treated for an ulcer condition and the doctor discharged me for followup treatment on an outpatient basis, then I would be on our roll and treated for ulcers. Then all of a sudden I came in here with a broken leg. I would not be readmitted to the hospital for my ulcers because I am coming in for another condition. This would require a new application. This was where we were not statistically recording these readmissions properly.

Mr. EDGAR. So, this is a statistical change not a——

Mr. DERONDA. It is a statistical change.

Mr. EDGAR. OK.

Now, let me ask you to look at the bottom of that outpatient workload under "other." Other is up 60 percent, and I would like you to describe what other is.

Mr. DERONDA. The other outpatient visits are retirees, employee health, and nonveterans needing emergency care who may come in.

Mr. EDGAR. Is that a statistical change, or is it a real change?

Mr. DERONDA. That is a real change.

Mr. EDGAR. And what kinds of services are you providing there in terms of "other"?

Mr. DERONDA. Primarily employee health and retirees.

Mr. EDGAR. Retirees from the military?

Mr. DERONDA. Military retirees.

Mr. EDGAR. So, you are not just dealing with traditional veteran needs; you are dealing with——

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[1] See p. 35.

Mr. DERONDA. We are dealing with a retiree who requires medical treatment. This excludes dental care and eye glasses. Those areas where we have the resources, we are able to take care of the military retirees.

Mr. EDGAR. Do you get reimbursement from the Department of Defense for those?

Mr. DERONDA. We bill each month.

Mr. EDGAR. You bill the Department of Defense for this?

Mr. DERONDA. Yes, sir.

Mr. EDGAR. Do you have any other sharing agreements with any other military installations in the area of this facility?

Mr. BILLES. No.

Mr. EDGAR. Let me ask you a question about control. I notice that almost all of the hospitals in West Virginia are in different medical districts. Your focus is primarily heading in the direction of Washington and others are heading in other directions. Does that cause you any planning problems for the State of West Virginia to be three separate medical districts as opposed to all being in the same——

Mr. BILLES. I would say no. The districts are set up on the basis of being able to take care of veterans within a defined area and to have within that area most or all of the specialized services that a veteran would need for health purposes. And we are in a district that goes toward Washington, and Clarksburg is in a district that goes toward Pittsburgh.

Now, the VA doesn't recognize State lines when it comes to the administration of care. A veteran is eligible for care regardless to where he might find himself. He is not limited to space by State. The only thing is that if a veteran is in a State, the regional office will have his service record, and we deal with four different regional offices or should I say five, including the one in Washington.

So that, if all of us were in the same district and all of the four hospitals in West Virginia, we all deal with the same regional office. But we deal with Huntington, Roanoke, Washington, DC, Baltimore, as well as with Wilkes-Barre. These are the regions.

Mr. EDGAR. When was the last time you got together with all the medical directors from West Virginia, per se, to look at the extent of health care services provided by the VA for the State of West Virginia?

Mr. BILLES. I think it was a little bit more than a year ago. We met down in Charleston at the invitation of the Governor.

Mr. EDGAR. What was the outcome of that meeting?

Mr. BILLES. It was a time of meeting for a proclamation that was to be signed recognizing veterans, and we got together at that time for this purpose. We communicate with each other on the basis of need. As an example, I received a call from Beckley the other day saying that they had a patient down there that was from Maryland and they needed to move him up here. He was on an MA–1, and we gave them authorization within 48 hours to send him up here. That patient is still with us.

Mr. EDGAR. Thank you.

I have a couple questions of the Chief of Staff. You are about to open a brand new veterans' hospital. You know the quality of medicine that new facility will be able to provide. It will have addition-

al new equipment, new rooms, new sizing, new space, configurated toward providing modern health care in that facility. Are you concerned about any kinds of medical treatment or equipment that is not going to be available at the startup of the facility that should be in a new facility?

Dr. SJOGREN. I think we could function equally well or better than we are functioning now in this facility. There are one or two areas that we had felt a need; one of these is a CAT scan. However, we do not have many emergency type or traumatic type patients coming. I think in the last month we may have had 12 that we sent to the local hospital in Martinsburg for a CAT scan. The rest of them are taken care of in Washington. So, I don't think that is a real problem. It would be more convenient to have one.

The other problem that we are perhaps going to see more of is radiation therapy. We do not have that capability here. We contract for this service with hospitals near where the veteran lives. Some of them do go down to Washington. Radiation therapy is usually a long-term treatment. It is not practical to keep the veteran in a hospital for that time. I think this is increasing every month, and I think that is due to state-of-the-art changes.

Mr. EDGAR. If there was a CAT scanner in the brand-new facility would physicians in this hospital utilize that as a diagnostic technique more aggressively than they do at present where you have to contract out for that service?

Dr. SJOGREN. I don't think there is any question.

Mr. EDGAR. Would that assist in the delivery of health care to the veterans?

Dr. SJOGREN. Yes, it would be—certainly it would work here, I think.

Mr. EDGAR. Would there be a renal dialysis machine or equipment in the new——

Dr. SJOGREN. No, we will not have renal dialysis equipment. We use local renal dialysis units where we get the contract.

Mr. EDGAR. What kind of intensive care facilities will you have?

Dr. SJOGREN. We will have a surgical intensive care unit with four beds. And the [MICU] the medical intensive care unit will be 8 beds, which is down from our present 12.

Mr. EDGAR. Is there any other comment that you would like to make about the new facilities? If you had a wish list and you were going to be able to tell Dr. Custis in Washington or the House and Senate what you would like to see placed on the agenda at some point for this new facility, what would it be?

Dr. SJOGREN. I have only been here 2 years, and I didn't go through the initial planning. I understand that there were a number of things that would have made the new hospital more efficient that we didn't really have much input into. I think there is nothing we can do about that now. This is going to take more FTE to maintain some of these—to do some of these procedures.

Mr. EDGAR. Let me ask the medical director, the hospital director, a couple of questions. Will the new hospital be fully computerized?

Mr. BILLES. Yes, not initially. Initially we have three areas. These are going to be pharmacy, admissions and the laboratory.

These will be the three areas initially that will be in the core. But then added to this incrementally——

Mr. EDGAR. Will the outpatient pharmacy be part of this computerization?

Mr. BILLES. Yes.

Mr. EDGAR. Why is it phased rather than the whole hospital being ready for occupancy and being fully computerized?

Mr. BILLES. Since it was funded in such a way as to bring the most needed or perceived to be the most important elements first and then to build on that rather than trying to do everything all at one time. It is going to be quite a chore as it is, but we will add to this—the initial computer will have the core to take substantially more than what we will initially put on it. But then we will build into that as we go by adding incrementally other services. The pharmacy is one of the prime areas because this is a very important area to bring under this.

Mr. EDGAR. Will you have as part of your new additional employees, some people to help train in terms of computer literacy?

Mr. BILLES. That is right. We have brought on board already a person who is an expert at it. He has done a fine job with us to this point.

Mr. EDGAR. We were in the Bay Pines facility in Florida which is also a brand new hospital. I was really surprised by the fact that we had the shell of a really nice hospital, but we didn't put the pieces all together. They did not have a CAT scanner; they did not have some of the very expensive modern equipment, some of the equipment that physicians need in the routine provision of their care. And I am concerned as the Chair of this particular subcommittee that if the VA is going to construct a facility, that we do it and that we have a sense of immediacy to, or ability to, provide good service in that facility. And that is the reason for my questions.

Let me ask you a couple of additional questions.

In the nursing home area, with the questions that Mr. Mollohan was asking about the aging veteran population, does this facility have any plans for respite care where you would provide for a patient perhaps for a weekend or a week and relieve the family and friends from the responsibility of caring for that same veteran at home while they rest from that care? And is there any active plan to provide for training of people so that they can be caring for veterans in a home setting?

Mr. BILLES. This is something that we have been doing over the years and long before it became a program per se in the VA. We would take a veteran and bring him into the hospital under the provisions of checking the veteran out, and meanwhile, the family could have some respite from the labors of looking after that veteran on a continuing 24-hour basis. We have been doing that over the years. We don't have a formal program for that, but we do it all the time.

Mr. EDGAR. What kind of home health care agencies exist in your immediate area that could be utilized if there was a flood of aging veterans and you were not able to provide institutional care for these veterans?

Mr. BILLES. I don't know of any that would be available. Do you, Mr. Chabot? This is Mr. Chabot, acting chief of social work. Would you answer that?

Mr. CHABOT. There is a system called Home Health Call in most communities around us. We have these and utilize them frequently.

Mr. EDGAR. Thank you.

We are looking at some legislative initiatives and trying to fund some home health teams and home health delivery systems within the VA. Every time the VA goes to OMB for funding, they get turned down. We are providing some additional funding in next year's budget for that particular item and think that is going to be something of importance for the future because even if we started constructing twice as many hospitals, twice as many outpatient clinics, we are not going to be meeting the emerging need. And we are going to have to figure out home health based and community based ways of providing service using shared agreements with community hospitals and home health delivery professionals.

Mr. BILLES. Mr. Chairman, one of the things that I didn't mention before was the fact that, in connection with Mr. Mollohan, there is a fact that we have applied for a GRECC here, and we think that we have a very good setting for it. We were turned down because we were not as closely affiliated as the requirements set forth. However——

Mr. EDGAR. For those in the audience, a GRECC is Geriatric Research Education Clinical Center.

Mr. CHABOT. Yes.

Mr. BILLES. And now, we are applying for one as I think on a district basis, which would include and encompass Washington, Baltimore, Fort Howard, Perry Point, and this hospital having played a major role in this process.

We hope that this will come to pass.

Mr. EDGAR. Thank you.

I have no additional questions of this panel. Does any member of the panel have any additional comment they would like to make or clarification?

Mr. DERONDA. Mr. Chairman, in regard to the problem that the VA has with the out-placement of its elderly veterans, right now we have approximately 30 patients in this hospital that could be out-placed in a nursing home if the nursing beds were available in the area. This is one of our problems.

Another problem is in our personal care placement. These veterans have to have their own funds in order to be placed in a personal care home. This inhibits us also in placing certain veterans in the community where there are personal care homes because they don't have the means to support themselves nor do we. This also prohibits us from out-placing some of our older veterans when they could be out-placed in the community. This has been a problem for many years.

If there was some way that this program could be subsidized, then we would probably be able to get more elderly residents back into the community and also in the nursing care program. We know that we have a 6-month restriction on this with a 6-month extension which must be approved by the Director. There are many

veterans out here today that are losing their medicaid benefits. And because they are losing these benefits, they are returning to the VA hospitals, and they are beginning to tie up beds. If there was something there that could be done where we could subsidize this, I think we would be much better off.

Mr. EDGAR. Thank you very much.

Are there other additional questions, Mr. Mollohan? Mr. Staggers?

Thank you very much. I appreciate your testimony.

Mr. EDGAR. Our next witness will be Mr. William Sites, the chairman of the VA Center Committee, Martinsburg-Berkeley County Chamber of Commerce.

Mr. Sites, welcome to the committee. I appreciate your patience this morning. We look forward to hearing your testimony.

**STATEMENT OF BILL SITES, CHAIRMAN, VETERANS' ADMINISTRATION CENTER COMMITTEE, MARTINSBURG-BERKELEY COUNTY CHAMBER OF COMMERCE**

Mr. SITES. Mr. Chairman, Mr. Staggers, and Mr. Mollohan, I am Bill Sites, chairman of the Veterans' Administration Center Committee of the Martinsburg-Berkeley County Chamber of Commerce.

Over the past years, we have maintained a close relationship with this Veterans' Administration medical facility and feel that it is a very important contributor to our area, and we are contributors to the center. The economic impact on our community by the Veterans' Administration center is significant.

Our medical community benefits from this facility, and we feel that the private sector is a contributor to the VA center medical expertise, professionally and through community volunteers.

Realizing the mutual benefits, we urge the continual upgrading of the facilities to support the new replacement hospital. Of particular importance is the completion of a new water treatment facility, research center, and the new laundry.

I thank you.

Mr. EDGAR. If you will just remain for a second. I have a couple of questions for you. You are not going to get away that easy.

Let me yield to my talented colleague here, Mr. Staggers.

Mr. STAGGERS. Thank you, Mr. Chairman.

Mr. Sites, I would agree that the community works very well with the VA, and the VA works very well with the community. What are some of the problems with some of the facilities which will be destroyed? Sewer projects for instance, and some of these other things? Does the community have any feelings about these areas?

Mr. SITES. Well, we are attempting to take over the sewer system. It has been turned over to a Berkeley County Public Service Sewer District, which will operate it as long—we are also in the process of having a countywide sewer system being developed in Berkeley County.

Mr. STAGGERS. Is there any major area, legislative or otherwise, that Congress could address to pave the way for the community and the VA to work together to come up with a better way?

Mr. SITES. Just generally, the VA.

Mr. STAGGERS. Yes.

Mr. SITES. I will try to answer your question, Mr. Staggers. I feel that this community and this VA center have a tremendous working relationship. To refresh you, we have been working for some 20-odd years, especially under the leadership of the deceased Dr. Bernstein, and we worked long and hard with the Congress to work for the fulfillment of a dream that we see sitting out here today.

The community feels that this is a tremendous asset, not only because they have it now, but what it renders to the community as far as care to the citizens. This hospital has an excellent reputation for the care it gives to the veterans in this community and this area.

Mr. EDGAR. Would the gentleman yield?

Mr. STAGGERS. I yield.

Mr. EDGAR. Let me ask you about the sewage treatment plant. Is the county or the community using any of the sewage treatment grant funds that were made available in Washington, $2.4 million annual commitment in each of its phases, in order to facilitate the construction and planning of that sewage treatment plant?

Mr. SITES. Mr. Chairman, not being actually involved in the Berkeley County sewer project, however, there are some of those funds being used. And to what extent, I go along with the Farmer's Home and the State of West Virginia. I cannot give you a percentage, but it has been utilized——

Mr. EDGAR. I also serve as an active member on Public Works and Transportation, directing and planning the sewage treatment dollars that we provide across the country. In 1980 we were providing $5 billion. That was cut because of the cost consciousness of the new administration to the $2.4 billion.

I read in the Washington Post last week that Mr. Ruckelshaus has a team looking at the possibility of eliminating any Federal commitment to the sewage treatment fundings, which will have a very massive impact on local communities depending on final phase dollars coming out of that pool for sewage treatment.

Some of us on the Public Works Committee think that, with the aging of our older communities and the expansion of some of our newer communities, that rather than eliminating those funds that they should be doubled back to the $5 billion commitment level.

I am nervous about any communities planning for sewage treatment funding. The administration is looking at something that should be done at the State and local level with no Federal involvement. It used to be 75 percent Federal money and 25 percent local money. It is now reduced to 55 percent Federal money and 45 percent local money.

If we allow the administration to do this, we might see the elimination of any Federal commitment which would put a burden on the community. So I hope that the chamber of commerce type of organizations would keep an eye on that. They tend to be the ones most eager to support the administration in their cost cutting, and it may have a very major impact on communities' planning.

Mr. SITES. Yes, sir, I would just like to add that it is of vital importance to our community that this sewer project does get underway because we will have a very serious consequence if we don't take care of this one.

Mr. EDGAR. One of the serious problems we face, and I could talk all day about water problems because that is another area of specialty, but we have a time bomb ticking away with the number of septic tanks that we have in our community and the number of ground water wells being infiltrated by hazardous substances, and the expansion in communities. But more importantly, the rehabilitation of existing sewage treatment plants put in place 35, 50, and 100 years ago, which are definitely not able to handle the time, the level, and the volume of sewage that they get.

Mr. SITES. I would like to add that, though, we are very grateful that the Veterans' Administration made available their sewage treatment plant here that we can incorporate in our system.

Mr. EDGAR. Mr. Mollohan, do you have a question?

Mr. MOLLOHAN. I have no questions.

Mr. EDGAR. Thank you very much for your testimony.

The next witness will be Mr. Harry Lord, deputy director, Martinsburg field office, West Virginia Department of Veterans' Affairs.

It is good to have the Lord with us today. I am a United Methodist minister by vocation and a Congressman by accident. So I have these religious jokes that I put in every once in a while.

## STATEMENT OF HARRY LORD, DEPUTY DIRECTOR, MARTINSBURG, WV DEPARTMENT OF VETERANS' AFFAIRS

Mr. LORD. Mr. Chairman and members of the Subcommittee on Hospitals and Health Care Committee on Veterans' Affairs, I would like to read a statement from Col. John W. Moon, the current director of the West Virginia Department of Veterans' Affairs.

Mr. EDGAR. Without objection, you may proceed.

Mr. LORD. The West Virginia Department of Veterans' Affairs is pleased to have this opportunity to present its views on the matters scheduled for your consideration today.

I would like to start my testimony by stating that Gov. John D. Rockefeller and the West Virginia Department of Veterans' Affairs is very pleased with the progress that has been made by the Veterans' Administration in funding medical construction in our four West Virginia medical centers. Because of the increasing average age of our WWII veterans, nursing home care is a realistic need for our approximately 243,000 veterans in the immediate future and we applaud your actions in making this a reality.

We here in West Virginia propose in our long range plans, possibly within the next 5 years, to increase our level of care at our Barboursville Veterans Home Domiciliary to include nursing home care.

We do have some concerns in specific areas of medical care that I believe this subcommittee should be made aware of in an effort to rectify and/or make recommendations for changes to such.

Area No. 1—6 month delays in issuance of CHAMPVA cards, civilian health and medical program of the VA, after initial application for such. I believe applications should not take this long for issuance.

Area No. 2—VA pharmacies automatically discontinue medication to veterans if their files fail to show current entitlement. I be-

lieve a letter should be sent to veterans permitting them ample time to provide evidence showing he is entitled to this benefit because of his service connection/housebound/aid and attendance/ WWI/et cetera.

Now, I would like to add that in this area, the Martinsburg field office, I have not encountered this problem. It is probably from some of the other field offices around the State. So, I really could not comment on that.

Area No. 3—veterans who lose entitlements to fee treatment by their personal physician because they have not used the fee card for 2 years should be notified prior to discontinuance of this benefit. There again, we realize that this is a regulation which we think should be changed.

Area No 4. VA pharmacies should be adequately staffed in order to process and fill prescriptions expeditiously.

The only other area of concern you have already addressed. That is outpatient care for nonservice connected veterans under post-hospital care and ambulatory care programs.

Finally, this department has 16 field offices throughout the State of West Virginia which refers those veterans in need of medical care to the four medical centers. I might add we have an outstanding working relationship with these medical centers and have the highest regard for the level of care they provide and are proud of the achievements they have made in updating the facilities with the most modernistic equipment in today's medical field.

Thank you.

Mr. EDGAR. Thank you very much for your statement.

Point 4 on your list of concerns I think will be addressed by the new computer system in the new hospital which will provide for both inpatient and outpatient pharmacy concerns. On point one of your areas of concern this committee will look into the 6-month delay in insurance, and the issuance of the CHAMPVA cards.

The VA pharmacy issue No. 2—I am not exactly sure how that will be addressed, but we will pursue that with the hospital director. We appreciate your raising it.

I would like to ask you questions related to your State veterans' home and domiciliary unit.

I hear that is not a very nice place to go and live, am I wrong in that?

Mr. LORD. I certainly disagree. I have only been there one time, for a tour, and I would say that it is comparable very much so, to the new domiciliary here.

Mr. EDGAR. Do you like it?

Mr. LORD. Yes, very much.

Mr. EDGAR. Have you used the Federal funds for renovation of that facility?

Mr. LORD. I really can't answer that question. I assume they did.

Mr. EDGAR. We provided some increases in the per diem rates last year with the legislation I had been involved in. The Federal share of per diem is about 30 percent, 70 percent from the State. And the construction grant is 65 percent Federal and 35 percent State.

Are there plans for the State to expand the number of State related homes?

Mr. LORD. Not any more homes at this time. At that particular home, I think they have 130 beds right now and will be expanding to 200.

Mr. EDGAR. Let me encourage you to really take a look at that program, not only in terms of expansion of beds, but developing a partnership with the Federal Government in expansion of that program because the Federal Government has not been able to provide a sufficient numbr of facilities like you see here.

We just are going to be limited in terms of the amount of dollars and buying more MX missiles, B–1 bombers, neutron bombs, nerve gas canisters, and other things which are taking us to a $2 trillion commitment on defense over the next 5 years.

That is in itself going to drive the deficits higher. States are going to have to provide services when those services are not being provided by the VA to the veteran. The Federal Government system will be strained very quickly.

I think that the State and Federal partnership is one that ought to be continued and expanded.

I am pleased that you don't agree with the things I have heard about that facility. I don't have the time today to visit it, but we have visited a number of State homes and have been pleased at the transition between what they used to be and what they are today, and we should give them the little bit of Federal funding which has been committed.

We are pleased that the budget in that category has been increased for fiscal year 1985 and we hope to put additional pressure on the Office of Management and Budget to have more State homes established.

I have no further questions.

Mr. Staggers.

Mr. STAGGERS. In the interest of time, Mr. Chairman, I will skip the questions.

Mr. EDGAR. Mr. Mollohan.

Mr. MOLLOHAN. No, Mr. Chairman. I would like to thank the witness for coming.

Mr. EDGAR. Thank you very much for coming.

Now, I would like to call on our panel of veterans organizations. Mr. Yurish, Mr. Evans, Mr. Seaman, and I think there is a gentleman from the DAV who is here as well. If he will come forward at this point.

Mr. Knestrick, is he here?

Please gather around the microphone, we are going to have to ask you to pass your microphones. We would like you to identify who you are for the record when you give your statement. We will hear first from the DAV, then from The American Legion and then from the Veterans of Foreign Wars.

You can sit closer around the table here. It would be very helpful.

Let me ask the DAV to go first. I think there are two repesenting the DAV and we will ask each of you to identify yourself and the full text of your statements will be made a part of the record.

We ask, in the interest of time, that you summarize as much as possible.

## STATEMENT OF CHARLES YURISH, FIRST JUNIOR VICE COMMANDER OF THE DAV DEPARTMENT OF WEST VIRGINIA, AND LLOYD KNESTRICK, DAV STATE VAVS REPRESENTATIVE FOR WEST VIRGINIA

### STATEMENT OF CHARLES YURISH

Mr. YURISH. Good morning, Mr. Chairman. My name is Charles Yurish. I am the First Junior Vice Commander of the Disabled American Veterans Department of West Virginia.

Accompanying me this morning is Mr. Lloyd Knestrick, the Disabled American Veteran State Chairman of Veterans' Administration Volunteer Service for West Virginia.

It is a pleasure for me to appear this morning on behalf of the Department Commander, Eugene DiClemente, and the more than 8,000 members of the Disabled American Veterans in West Virginia, regarding our views on the VA's ability to meet the health care needs of veterans, and particularly aging veterans, as well as the quality of inpatient and outpatient care provided by the Martinsburg VA Medical Center.

Mr. Chairman, we are pleased and most appreciative that you and our West Virginia Congressmen, Mr. Staggers and Mr. Mollohan, scheduled this hearing in our area in order to provide us with this opportunity to express our views on these important subjects.

The Disabled American Veterans is concerned, as I am certain you are, over the lack of growth—artificial caps if you will—that have been imposed upon VA outpatient and inpatient episodes of care, as well as medical personnel staffing for many years.

While there has been some expansion in additional nursing home care beds, for which we are most grateful, the VA health care planning for our veterans has failed to acknowledge the growing demand that has been and will continue to be placed upon the VA's medical care system.

This problem, coupled with the fact that costs associated with the VA medical care programs have, for many years, failed to keep pace with inflation in health care costs, further confirms the negative growth of the system.

We hope the subcommittee, and indeed the entire Congress, will keep these very important concerns in mind when addressing the needs of the VA medical system now and in the future.

At this point, Mr. Chairman, I will ask Mr. Knestrick to briefly outline the DAV views on quality of inpatient and outpatient health care provided by the Martinsburg VA Medical Center.

Mr. EDGAR. Thank you very much.

Please identify yourself for the record.

The full text of your statement will be made a part of the record.

### STATEMENT OF LLOYD KNESTRICK

Mr. KNESTRICK. Good morning, Mr. Chairman. I am Lloyd Knestrick, State VAVS chairman.

During the period I have been here, I have seen patients in all conditions and this type of patient requires nursing staff with special qualifications.

It has been my experience that the majority of the staff have those qualifications. The vast majority of inpatients here have nothing but praise for the care they receive.

However, outpatient care is another matter. The complaints center mostly on regularly scheduled appointments and prescriptions. Appointments require waiting maybe 1 to 2 hours and if an outpatient is scheduled to see three or four doctors in a day, the pharmacy may be closed before he can submit his prescriptions.

Another problem is the recent elimination of free meal tickets at lunchtime. They used to be given when a patient was required to remain here over lunch hour and they may have had enough money for busfare home.

The final shortcoming I would like to mention is the lack of a therapeutic pool for treating patients with chronic pain. The pain patients are mostly sent to Washington VA Medical Center's pain clinics. But after they are released from that clinic, they still have need of a therapeutic pool. However, none is available at this facility and I understand one was in the budget but it was deleted.

The average age of our veteran population is increasing and with it additional problems that come with aging, so I feel that more thought and planning must be given to increasing the staff for outpatient care.

I would recommend reinstating meal tickets for lunch and allotting sufficient funds for the purpose of a therapeutic pool.

In conclusion, I must say that given the present staffing and facilities, the quality of outpatient care provided here at Martinsburg is very good.

Gentlemen, thank you for your kind attention and now Mr. Yurish would like to make a closing remark.

[The statement of Mr. Knestrick appears on p. 40.]

Mr. YURISH. In closing, Mr. Chairman, we wish to thank you, Congressman Mollohan and Congressman Staggers, for allowing us this opportunity to express our views on these important subjects.

Thank you.

Mr. EDGAR. Thank you.

If you will remain there and just pass the microphone over to the American Legion, we will hear from them, and then we will hear from the VFW last.

## STATEMENT OF LINCOLN COX, DEPARTMENT OF WEST VIRGINIA, THE AMERICAN LEGION

Mr. Cox. My name is Lincoln Cox. I am representing the Department of West Virginia and a past department commander on the legislative council, National Legislative Council.

I didn't have time to prepare a statement because I didn't hear about this until Saturday night, so I was rushed down here to attend this hearing.

Mr. EDGAR. The hearing record will stay open for a few days so that anyone who hasn't had an opportunity to prepare formal remarks can do so for the record.

Mr. Cox. The increase in medical care here is here and now. Unemployment and extensive hospital care has contributed to this problem.

This area has a very high percentage of aging veterans because it is a retirement area. People move in here in their retirement years from all over the country. Many came here from New England because of the high costs in that area.

The Vietnam veterans are not satisfied with the diagnosis and service of their problems. They have acute problems due to the treatment that they received when they returned home from the general public. They have problems, nervous problems, that they feel are not being addressed.

There have been some complaints about the delays in the pharmaceutical department and in the admissions department, which have already been addressed by the other members, so I will not go into that.

Vietnam veterans are not satisfied with their problems all over the United States, and this is not unique to this area. It would appear that this new facility has had poor oversight inspection of the various contractors and there have been some shortcomings because people have not been checked on regularly. I have had complaints about leaking roofs and so forth and you fellows have already heard about that.

There have been time-consuming delays in many sections, probably not due to the people in this facility but to other causes.

I would like to invite you to visit the Barboursville State Home and that you attend the Huntington State Hospital; it's not very far away.

There are many Legion posts that are contributing many hours of time to care for the people in that home and we feel it is doing a very good job. It's in the charge of Woody Williams, a Congressional Medal of Honor winner.

The department of West Virginia would like to have a transcript of this hearing.

Thank you.

Mr. EDGAR We will hear now, finally, from the VFW.

## STATEMENT OF JAMES SEAMAN, STATE COMMANDER, DEPARTMENT OF WEST VIRGINIA, VETERANS OF FOREIGN WARS

Mr. SEAMAN. Mr. Chairman, Congressman Staggers, Congressman Mollohan, I bring you greetings from the department of Veterans of Foreign Wars in the State of West Virginia.

My name is James Seaman. I am the State commander of the Veterans of Foreign Wars. It is an honor for me to appear here this morning before this subcommittee and it is an honor to have you come to West Virginia to address the problems of the veterans of West Virginia to hospital their needs and their care.

A few remarks that I want to say. The Martinsburg Hospital, in my opinion, has done an outstanding job for the veterans in this area. I have been in the other hospitals in this State and I think that the care here is very good and the veterans here can feel proud in what they have.

In the outpatient clinic, I do know that there have been some complaints of time involved when they come in to see doctors. Some say the period of time for waiting to see doctors is too long, and the same with the pharmacy.

There are problems that come from the increase in number of veterans who are using the facilities. We need to increase the care that they get at these facilities so that the time in delay is not very long. We know that as time goes on that the increasing veterans population, the aging population, is going to continue to grow, as we have seen in the past few years.

This is one great concern to the hospital, that we have more facilities available to these beds, the nursing home beds, the domiciliary beds. This is going to become more acute than it is at this time because, as these veterans grow older, they have no one to take care of them. They do not have any family in which they can stay and they are going to need this type of care which could be provided for them. For these people are the ones who defended our country. These are truly the people who went out and gave more above and beyond the common ordinary person.

These people do need special care, especially in a domiciliary and in nursing care beds.

I would like to also address the fact that when they go into these nursing homes, contract out nursing homes, it was mentioned that the VA pays for 6 months with a possible extension of 6 months.

True, this does happen, but if they enter this time, this does create a burden on this veteran if he does not have the income to sustain his stay in this home which we are looking at, like $1,300, $1,400 a month, which is very expensive.

We need to address the care for these veterans that they can continue to have the care that they need and not be put back on the welfare rolls.

Mr. Chairman, I thank you for the privilege of appearing here this morning.

Mr. EDGAR. Thank you very much.

The comment you made about the outpatient pharmacy I think will be resolved significantly with the new computer system and the new hospital.

I would ask that all of the hospital personnel who are in the opening panel who can stay to listen to your comments and to hear the different concerns that you have about waiting times, et cetera.

We will pursue that with them individually. And as far as the transcript of the hearing is concerned, we will make printed copies of that available throughout the State through the elected Representatives here.

Also, the comment about Barboursville, I am glad to hear that I am wrong and that what I have heard is wrong and that you are proud of that facility. I just hope that you will continue to look at the ways in which those State veterans' homes can begin to take on more of the load that will be coming, because I am not certain that the Federal system can care for that load beyond the year 1990 as adequately as it needs to be.

Let me yield to my colleague, Mr. Staggers.

Mr. STAGGERS. Thank you, Mr. Chairman.

You may have noticed, and I am sure the Members here have noticed, how bright and intelligent and good looking Mr. Seaman is, and I think that's because he's from Keyser, WV.

Mr. EDGAR. Is it in the drinking water?

Mr. STAGGERS. We're very proud of Mr. Seaman. It is my hometown, and we are very proud. The whole town is proud of the leadership exhibited by the VFW, and I did want to point that out to you and to the chairman.

Also, I agree with the other comments about this being a retirement area, and I think that stretches from Jefferson County all the way to Mineral County, even further.

Because of the price of land, more and more people are moving into this area.

I am concerned about the lack of growth, also, the lack of timing for the retirement facilities. It is the quality of life which we offer here in West Virginia. I think that is something we need to address and I am very much concerned.

Mr. EDGAR. Thank you.

Mr. Mollohan.

Mr. MOLLOHAN. Mr. Chairman, I noticed that Mr. Seaman didn't drink the water at our VFW meeting Saturday night and I wondered why it was. Now I know; I know he prefers that Keyser brand.

I thought these gentlemen, really in every distinct, capsulized form, presented these problems to us very well, and it's very valuable to have your input.

I share my appreciation with the chairman and Congressman Staggers also.

Thank you for the hearing. It was very valuable.

Mr. SEAMAN. Mr. Chairman, could I make one comment?

He spoke of the Barboursville Veterans Home and these other gentlemen referred to it; I did not at that time.

The Barboursville Veterans Home is one of the greatest that there is. I have personally toured that facility. I have been there, I have eaten with the patients at Barboursville and I have talked with them, and the residents there are very pleased with the facilities. It is very clean; it is very modernly equipped and it is very well staffed. The food is excellently prepared.

These veterans do have freedom to prowl to and from this home; they can go into town, they are not restricted in this.

I would say that any of you who are down there that it would be well worth your time to tour this facility.

At present they are building the one new section of the home with furniture. This is why there are only at the present time 130 people there. The new section, at this time, the furniture is being placed in it and then it will be open for residency to fill that section of the building.

Mr. EDGAR. I noticed you talked about the eating is good; did you drink the water?

Mr. SEAMAN. Yes, sir, I did drink the water.

Mr. MOLLOHAN. Mr. Chairman, at this time I'd like to ask one question.

Mr. EDGAR. I yield to the gentleman.

Mr. MOLLOHAN. I know we're really pressed for time but I'm interested in outpatient medication for non-service-connected veterans.

Do you all have any comments on that at this facility or any facility?

Mr. SEAMAN. Well, the medicine for outpatient non-service-connected veterans is not available. On this I can personally testify to. I have a disability which I must take medication for at all times.

Mr. EDGAR. Which hospital are you talking about?

Mr. SEAMAN. I was out here at the Martinsburg Hospital. I have also talked to the doctors at Washington Hospital and due to the fact that this is a disability that is not service connected they will not furnish medicine to me for this even though I am a veteran.

I did have a service-connected disability but the disability that I am referring to is nonservice connected and the VA does not furnish medicine for this type of disability, nonservice.

Mr. MOLLOHAN. Thank you.

Any additional questions?

Let me just say to all of you on the panel we appreciate your statements and your patience this morning. We also appreciate the leadership that you now have on the House Veterans' Affairs Committee. I hope that the VA and the American Legion, DAV, and other service organizations in the State of West Virginia recognizes the value to you of having Members in the House of Representatives who not only are interested in veterans' needs but also serve on the committees and subcommittees that have direct jurisdiction over veterans.

When I first went on the House Veterans' Affairs Committee from Pennsylvania there were no other Members from Pennsylvania even though we had a delegation of 23 Members, or 25 Members, at that time in the House of Representatives.

It is really critical to try to encourage and keep your delegation represented within the committee, but we don't have enough slots for every State to be represented.

It doesn't mean that we don't care about the needs of other States, but as long as you have outstanding Members of Congress to serve on the House Veterans' Affairs Committee it gives you access to the medical budget, it gives you access into housing and education issues, and particularly gives you access into compensation and pension.

With all of the pressures in Washington to cut budgets the VA is not exempt from that particular concern. I hope that you will work with your two Members from the State who serve with us on the House Veterans' Affairs Committee, sharing with them your concerns, your frustrations, your anxieties, as well as your congratulations when we do something right.

Last year, for example, these gentlemen helped me extend for four additional years the readjustment counseling centers for Vietnam veterans. They also helped us to allow the atomic veteran to be fully serviced through the VA health care system. We designated July 16 as Atomic Veterans Day and there has been a major focus on the 250,000 veterans who were exposed to nuclear radiation.

We have also done some work in identifying some systemic diseases related to agent orange and are pursuing the agent orange studies very aggressively.

In the last few years the Veterans Committee has become much more aware of Vietnam era concerns. Not forgetting the World War II, World War I, the Korea era veteran, but the particular

needs of Vietnam veterans have come to the consciousness of Congress as a result of some of the newer Members.

All of your national organizations testify before us. You have been down there probably to see that statement being made and it is real important that that statement be made by your national organization. But I can tell you, it is what you do one-on-one with your Members that gives us the impact in shaping veterans' legislation. It is tough when the national commander comes to listen to all of their concerns. It is much more important when you take it upon yourselves to be educated.

Thank you for your time and your energy today.

Mr. COX. Mr. Chairman, I have two members of that Berkeley County post here and one of them has a question or two they would like to ask.

Mr. EDGAR. We only have about two additional minutes, but if he will stand and offer his question.

Mr. RITTENOUR. I have had both questions answered.

Mr. EDGAR. You have both problems solved. Thank you very much.

Any additional person in the audience who has a comment or a question that they would like to raise before the hearing is adjourned?

If the gentleman would step forward to the microphone and I will excuse the members of the panel.

Would you identify yourself for the record and keep your statement brief?

Mr. TOLL. Thank you very much, Mr. Chairman.

My name is Grant Toll and I am a patient here in domiciliary and also the moderator of a patient group that meets once a week to discuss various procedural and fiscal problems here at the center.

I would like to pay my compliments to the staff for a very outstanding job that they have done over the years that I have been here. We who are here in the domiciliary, there are some 500 members of the domiciliary. It is a turnover group. Some stay longer than others. Some are psychiatric problems; others are neurological and physical. There are certain members of the domiciliary who will never be able to leave.

I would like specifically to bring up two points that are, I believe, beyond the purview of the staff here to do anything about.

First is transportation. Greyhound Bus Co., several months ago stopped transportation between Hagerstown and Martinsburg. This proved a great handicap, not only to the members of the domiciliary but to the families of these people who in many cases have low incomes and are unable to afford an automobile.

Second, the outpatient population, as you know, is drawn from a large area. Likewise, in many cases, it is not able to afford automobile transportation. They had to rely on Greyhound.

The reason I brought up Hagerstown is it is a sort of centering point for the various bus lines going to various points in this area. Without that transportation to Hagerstown they have to rely on taxicabs which costs them $20 or $25 each way. It is an expensive proposition.

We need to have some agreement, some way that we can substitute for Greyhound. We have another bus line that is willing to enter into discussions on this matter on a limited service basis with a guarantee of a certain minimum number of riders each way.

You can understand, of course, their concern of these problems and we are wondering just how they are going to be able to manage it.

This transportation problem is very real to us. It does inhibit a lot of the people here from going on leaves or passes and so forth, getting away from the center. While the center is nice, it is always good to get away for a while, too,

Mr. EDGAR. I thank the gentleman for his statement about transportation.

You had one additional point that you wanted to make?

Mr. TOLL. Yes. There is a certain point that I would like to make. That is the maximum income that is permissible for people allowed in the domiciliary. It is $415 a month. This many of us consider to be unrealistic in view of the fact that there are many people drawing somewhat more money a month from social security who are kept out of the domiciliary and who have a real need for this domiciliary care.

I think that the figure of $415 should be reviewed in view of inflation over the last number of years and looked at perhaps in a more realistic manner.

Mr. EDGAR. I thank the gentleman for his comments. I appreciate that.

If there are no other comments to be made, the hearing now stands adjourned.

[Whereupon, at 11:47 a.m., the subcommittee was adjourned.]

# APPENDIX

STATEMENT OF I.V. BILLES, DIRECTOR, VA MEDICAL CENTER, MARTINSBURG, WV, TO THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

The Veterans' Administration Medical Center at Martinsburg, West Virginia, currently is operating a 414-bed general medical and surgical hospital, 120-bed nursing home, and a 540-bed domiciliary. This Center is part of the VA's Medical District #6 which also includes the Medical Centers at Washington, DC; Loch Raven VAMC, Baltimore, MD; Fort Howard VAMC, Baltimore, MD; and the Perry Point VAMC, Perry Point, MD.

The present hospital and 340 beds of the domiciliary are housed in what was originally the Newton D. Baker Army Hospital. This facility was constructed in 1943, and was taken over by the Veterans Administration in 1946. The general construction is that of a complex of one-story brick buildings interconnected with corridors. It was considered a temporary structure built to last approximately seven to ten years. As you are aware; The Center is in the midst of a replacement program and to date a 120-bed nursing home and 200-bed domiciliary have been completed and are operational. The 357-bed high-rise hospital has been constructed and it is anticipated that it become operational in mid-1984. Upon move to the new hospital facililty, most of the remaining structures will be demolished. At this time it is planned to maintain 340 domiciliary beds with appropriate support services, some warehousing space, and the Chapel.

The present hospital operates 60 surgical beds which includes a 4-bed Surgical Intensive Care Unit, 22-bed Acute Psychiatric Service, and 332 Medical Service beds. The Medical Service is comprised of an 8-bed Medical Intensive Care Unit, a 4-bed Coronary Care Unit, a 20-bed Alcohol Rehabilitation Unit, 96-bed Long Term Care; 20-bed Pulmonary Disease Section, 20 beds of Oncology-Cancer Chemotherapy, and the remainder of the beds being distributed to Gastroenterology, Alcohol Detoxification and General Medicine. The Center is classified within the Medical District as a secondary care hospital, with tertiary care in orthopedics, thoracic and vascular surgery.

Surgical Service, although relatively small with only 60 beds, is quite active, providing not only general surgery, but vascular, thoracic, urology, orthopedics, ophthalmology, otolaryngology, and podiatric services. The area of vascular, thoracic, and otolaryngology are strong points in this program. The Ophthalmology Program is quite active, with services being provided by two full-time residents from George Washington University whose activities are monitored not only by our Chief of Surgery, but by faculty from that school.

The bed-care services are adequately supported through a full array of ancillary services which include rehabilitation medicine, laboratory, radiology, nuclear medicine, ultrasound, psychology, dental, medical media, chaplains, social work, dietetics, pharmacy, library, and the medical clinics such as electrocardiogram, electroencephalogram, and pulmonary function.

The facility is affiliated with the medical schools of Geroge Washington, Georgetown, and Howard Universities, and the dental schools of West Virginia University, Georgetown, and Howard Universities. The appointment of medical staff has been done on a very selective basis, hiring only highly qualified individuals whose credentials have been reviewed, not only by the Professional Standards Board at this Center, but by the Deans Committee of the affiliated institutions.

This Medical Center, as a primary service area, encompasses 23 counties in West Virginia, Virginia, Maryland, and Central Pennsylvania (see attachment). There are approximately 118,000 veterans in this catchment area. The rather large area that is covered by this Center is primarily rural, with a minimum of public transportation. As an example of this, the catchment area extends into Pendleton County in West Virginia (approximately 160 miles), north to Franklin County, Pennsylvania

(approximately 100 miles), northwest to Garrett County, Maryland (120 miles), and west to Grant County, West Virginia (135 miles). The distance required for our patients to travel does somewhat affect our method of treatment and length of stay in that many of the procedures that could be done on an outpatient basis in an urban hospital require admission to this Center for the convenience and well-being of the patients.

The average age of veterans in the general population is increasing, with the national median age of the World War II veteran at 63; Korean Conflict, 58; and Vietnam, 36. Approximately 51 percent of the veterans in the Martinsburg Medical Center PSA are between the ages of 45–64 years old. The projected increase in the average age of the veterans is based on the VA's assumption that no new wars will be fought.

The average age of our domiciliary patient is 59.3. The average age of the female domiciliary veteran is 57.5, with a range of 28–80 years old. Because we only have 16 domiciliaries in the VA system, our patients come from Pennsylvania, New Jersey, Delaware, Maryland, New York, and Virginia.

Major training programs include the previously mentioned ophthalmology residencies, two general practice residencies for dentistry in cooperation with Georgetown and Howard Universities, training of the senior dental students, and 4th-year selectives programs in surgery for students from West Virginia University. We train Physician Assistants for George Washington University and Alderson-Broaddus College; Nursing training is conducted in cooperation with Shepherd College, Shenandoah College, Berkeley County Vocational School, James Madison University, George Washington University, University of Maryland, and West Virginia University. Other training programs include Occupational Therapy—Virginia Commonwealth University; Dental Hygiene and Dental Assistant Programs—Allegany Community College; Respiratory Therapy—Shenandoah Community College; Audiologists and Speech Pathologists—West Virginia University; Social Work—West Virginia University, Shepherd College, University of Alabama, and Catholic University; Psychology—Catholic University.

With the move to the new hospital we are also anticipating the development of a School of Medical Technology in cooperation with Shepherd College. This would provide a source of trained medical technologists to the tri-state area.

Additional programs under consideration are the expansion of the 4th-year selectives available to medical students into the fields of nuclear medicine, internal medicine, and otolaryngology. We also are considering expanding these programs to include Marshall University and the West Virginia School of Osteopathic Medicine.

It should also be noted that negotiations are currently underway for the inclusion of a resident in vascular surgery, in cooperation with the George Washington University program.

Equally as important as the training of students is the continuing education programs for our medical staff and the medical community in general. This Center is accredited by the AMA for presenting Category I educational programs. All of our educational programs are made available to the physicians in the tri-county area of West Virginia, and also Winchester, Virginia, and Hagerstown, Maryland. There is also a biannual lecture series that is jointly sponsored by this Center and the Eastern Panhandle Medical Society. These programs provide the area with an easily available source for gaining current medical education.

One of the major strengths of this Medical Center is the providing of long-term care for the geriatric-type patient. This type of care is, as you are aware, one of the major concerns of the Veterans' Administration. This Center is meeting the needs by providing a 120-bed nursing home and 96 beds of long-term care within the Medical Service. The patients in these 96 beds are those who are in need of more intensive medical care than can be found in any skilled nursing home, including that of the Veterans Administration. To supplement the services, this Center outplaces an average of 82 veterans in community nursing homes at VA expense, and on any given day, there are normally 25 to 30 veterans in the acute care wards waiting placement into our long-term facilities or into a community nursing home. The demand for such care could be seen in that on the date of this writing, the Center has a waiting list of 78 for medical long-term care, and 17 for the nursing home. Although it is conceivable that more patients could be place in the community nursing home, we must point out that there is a scarcity of skilled nursing homes in this general area; therefore, the majority of the patients that can be placed are those that are defined as intermediate care. While this does meet some of the needs of the patient, it adds a burden to the Center in that we are gradually accumulating a greater proportion of patients requiring almost total nursing care. An example of this can be found in that when the nursing home was opened approximately three

years ago, the Veterans Administration recommended that there be a case mix of approximately 30% of the types requiring more skilled care, as compared to 70 of the types requiring less skilled care. At the present time our nursing home has 85 percent of the types requiring greater care and only 15 percent of those requiring minimum-type care.

The Domiciliary Program is one of 16 within the Veterans Administration. I would point out that approximately 65 percent of the domiciliary population has a major psychiatric diagnosis. This particular Center has always looked upon the domiciliary as an extension of the hospital and its treatment programs. There are many active programs in the fields of stroke rehabilitation, alcohol rehabilitation, vocational training and incentive therapy.

There is also under consideration a plan to relocate the Alcohol Rehabilitation Program from the acute hospital to the domiciliary. This would place the program in a strictly rehabilitation setting, as well as free 20 beds in the replacement hospital for long-term care use.

In general I would say that the major strength in providing health care at this Center is to be found in the overall atmosphere of compassion and concern that is prevalent not only in the direct Patient Care Services, but throughout the Allied Health and Administrative personnel. This milieu of caring, coupled with the talents of well-qualified professional and technical staff, serves to provide a high quality of patient care while meeting the emotional and social needs of the veterans we serve.

Replacement Hospital.—We will move from our 414-bed hospital to the new 357-bed replacement hospital in the summer of 1984. There will be 270 medical, 57 surgical, and 30 psychiatric beds. Although this represents a reduction of 57 beds, we will retain all of our ongoing clinical programs, with no new major programs anticipated.

The replacement hospital is a part of our overall construction program which began in 1978. Phase I of the project included the demolition of medical center buildings and rerouting of utilities, and Phase II included the construction of the 120-bed Nursing Home Care Unit, a new 200-bed Domiciliary, a Chiller Plant, and utilities. The steel frame, foundation, and concrete floors for the 357-bed replacement were part of Phase III, along with the seismic reinforcement for unnatural site conditions. Phase IV included the enclosing of the hospital and completion of the interior, landscaping, and parking lots.

Construction of Phase IV of the replacement hospital began in September, 1981, and was completed October 30, 1983, for a total cost of $40,997,483. The building was accepted by us on November 17, 1983. We will hold dedication ceremonies on July 1, 1984, and occupy the building shortly afterwards.

Since the building was turned over to us, we have been making preparations for occupancy. In addition, we are waiting for the completion of the Radiology suite, which was taken out of the major project and will be done as a change order to the major contract. We anticipate completion of Radiology by June, 1984.

Delays were experienced in receiving authorization or approval to proceed with necessary projects due to Public Law 98-45, dated July 12, 1983. This law states, "That no funds from any other account may be obligated for constructing, altering, extending or improving a project which was approved in the budget process . . . until one year after final acceptance of the project by the VA." These were the ADP site preparation, office space for Engineering and Supply Services, the patient monitoring system, and intrusion alarm systems.

A service elevator, water treatment plant and research space were deleted from the original project, due to the lack of funds. After occupancy, we will conduct a traffic study to determine our need for the elevator. The water treatment plant was submitted in the FY 1985-1989 Five-Year Facility Plan on July 26, 1983, as a $1.9 million minor construction project. To date, we have not received approval.

The fifth phase of the project will include demolition of certain hospital buildings on the 50 and 100 ramps, provide additional landscaping, add more parking spaces to the outpatient/visitors parking lot, and provide roadways. The demolition of the existing buildings will involve removal of the asbestos, which will add significantly to the cost of Phase V.

The scope of changes in the new hospital is significant. The new hospital has 515,000 sqare feet, or approximately 60% more square footage than the current hospital. Due to the decrease in beds, it is necessary to increase our turnover rate and decrease the length of stay in order to serve the same number of patients we serve now. (see attached workload sheet).

In addition, the scope of Pharmacy and Supply Processing and Distribution will be expanded greatly due to new functions they will acquire. Full implementation of

the unit dose system and expansion of the Pharmacy from one location to seven requires additional resources.

In order to accommodate the square footage increase, changes in the scope of services and increased turnover, we were given 69 additional FTE which were distributed primarily to Building Management Service, Supply Service, and Pharmacy Service.

The replacement hospital has a marked increase in new automated and highly technical equipment and systems. These systems include a new Chiller Plant which controls and monitors the central heating and air conditioning in the hospital, Nursing Home Care Unit and Domiciliary; the pneumatic tube system; the automatic Dietetic equipment and refrigeration units; the nurse call systems; a radio entertainment system; the auxiliary power systems; a linen/trash system; sterilizers; hydraulic/traction elevators; and the master antenna TV system. All of these new systems demand a more highly trained mix of engineering personnel who have a working knowledge of the routine maintenance required. Much of the equipment will have maintenance contracts for major repair work.

With the construction of the hospital, all of our fire and safety deficiencies will be corrected. For those buildings scheduled to remain, corrective action has been taken on the fire and safety deficiencies.

Although we do not anticipate any major program changes, we will have the capability of adding new activities and procedures: The Chaplain Service will be able to broadcast services from the Chapel to the patients' rooms via our MATV system; the Library/Medical Media will be able to distribute patient education material via the MATV system; Supply will have a centralized silver recovery area; cardiac monitoring of patients in Life Support Room (emergency area); Pharmacy has walk-in vaults for controlled substances; Audiology will initiate ENG (Electronystagmography)—to evaluate patients who complain of dizziness and ABR (Auditory Brainstem Response), a method to test patients with brain tumors; Surgical/Medical will initiate non-invasive vascular studies; Medical Service will implement its computerized electrocardiograph (EKG) system, which interprets EKG program; initiation of computerized pulmonary function studies; Medical Service will install a computerized patient monitoring system for intensive care units; and the Laboratory will expand its Therapeutic Drug Monitoring tests, and decrease turnaround time for all test results, including microbiology.

As mentioned in my opening testimony, we have a very dedicated staff, and they have worked diligently throughout the planning for our move.

### VIETNAM ERA VETERANS

We currently have 39 Vietnam Era veterans in the hospital and 57 in the Domiciliary.

Since 1978, an informal discussion group of 10–22 Vietnam Era veterans has been held to discuss what happened in Vietnam and how it affects their present life.

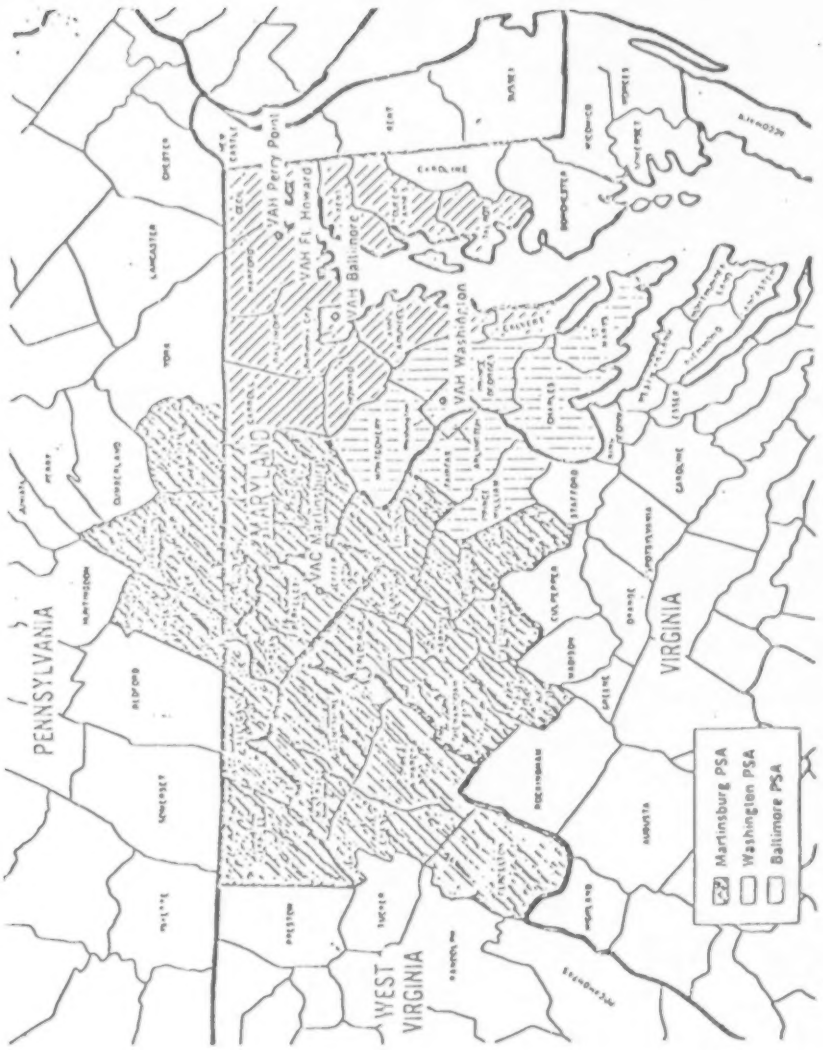
We currently have 100 Vietnam Era veterans enrolled in seven (7) Vietnam Readjustment Counseling clinics. The medical center contracts with private firms to provide job and career counseling, family and marriage counseling, individual readjustment, group readjustment, substance abuse counseling, and social services counseling and referral.

### FEMALE VETERANS

The medical center is very sensitive to the needs of our female veterans, and every effort is made to provide them privacy and a full range of services. We currently have six (6) female patients in the hospital, 46 in the Domiciliary and three (3) in the NHCU. Services such as women's clothing and a beauty shop are on station for our female veterans. The majority of the female veterans are World War II Era. However, within the last year, we admitted an increased number of younger female veterans into our Domiciliary program.

### SPECIAL PROGRAMS

The medical center has completed 701 Agent Orange examinations, 33 P.O.W. examinations, and 22 Radiation Exposure examinations. We do not have a backlog on any of the above special category exams.




MARTINSBURG VAMC PRIMARY SERVICE AREA

VETERANS' ADMINISTRATION MEDICAL CENTER, MARTINSBURG, WV 25401

MEDICAL CENTER PROFILE

A. Service area. The VA Medical Center Martinsburg's service area encompasses twenty-three (23) counties in four (4) states with a total estimated veteran population of 118,000.

Pennsylvania: Fulton County, Franklin County, Adams County.

Maryland: Washington County, Frederick County, Allegany County, Garrett County.

Virginia: Loudoun County, Clarke County, Frederick County, Shenandoah County, Warren County, Fauquier County, Rappahannock County, Page County.

West Virginia: Jefferson County, Berkeley County, Morgan County, Hampshire County, Mineral County, Grant County, Hardy County, Pendleton County.

## MEDICAL CENTER PROFILE

| | Fiscal year— | | | |
|---|---|---|---|---|
| | 1980 | 1981 | 1982 | 1983 |
| (1) Operating beds: | | | | |
| Medical | 421 | 322 | 332 | 332 |
| Surgical | 70 | 70 | 60 | 60 |
| Psychiatric | 22 | 22 | 22 | 22 |
| (2) Turnover rates: | | | | |
| Medical (percent) | 91 | 103 | 121 | 127 |
| Surgical (percent) | 206 | 234 | 219 | 230 |
| Psychiatric (percent) | 110 | 103 | 120 | 141 |
| (3) Length of stay: | | | | |
| Medical | 34 | 50 | 24 | 25 |
| Surgical | 13 | 13 | 14 | 12 |
| Psychiatric | 26 | 22 | 19 | 19 |
| (4) Patients treated: | | | | |
| Medical | 4,499 | 4,503 | 4,513 | 4,799 |
| Surgical | 1,272 | 1,402 | 1,339 | 1,454 |
| Psychiatric | 248 | 265 | 295 | 342 |
| (5) Outpatient workload: | | | | |
| C&P | 490 | 343 | 474 | 487 |
| 10–10 | 5,919 | 6,522 | 5,976 | 10,058 |
| Service-connected | 15,452 | 17,256 | 17,403 | 18,760 |
| Nonservice connected | 25,823 | 27,150 | 26,502 | 27,262 |
| Employee health | 4,856 | 3,931 | 3,080 | 3,263 |
| Collateral | 256 | 530 | 455 | 547 |
| Other | 8,193 | 10,597 | 10,765 | 13,038 |
| (6) Percent service-connected: | | | | |
| Inpatient (percent) | 22 | 35 | 26 | 26 |
| Outpatient (percent) | 26 | 26 | 27 | 26 |

STATEMENT OF DISABLED AMERICAN VETERANS, DEPARTMENT OF WEST VIRGINIA

Good morning, Mr. Chairman. I am Lloyd Knestrick and, before my appointment a month ago as State VAVS Chairman, I had been the DAV Hospital Representative here at Martinsburg for three years. During that period I have talked to many patients and seen many others who were not able to communicate by the spoken word but, perhaps, only by a blink of the eye or even just a blank stare. This type of patient, in my estimation, requires a nursing staff with special qualifications and it has been my experience that the majority of the staff here do have those qualifications. The vast majority of inpatients here have nothing but praise for the care they receive.

Outpatient care, however, is another matter. The complaints center mostly on the waiting periods for regularly scheduled doctors appointments and for prescriptions. Appointments commonly require waiting from one to two hours and, if an outpatient is scheduled to see three or four doctors in one day, he will spend the entire day here and the pharmacy may be closed before he can submit his prescriptions.

Waits for prescriptions are commonly one-and-a-half to two hours, which is in addition to the time spent waiting to see physicians.

Another problem outpatients complain about is the recent elimination of free meal tickets at lunchtime which were given when the above waiting forced them to remain here over the lunch hour and they may have had only enough money for busfare home.

The final shortcoming of this facility which I would like to mention is the lack of a therapeutic pool for treating patients with chronic pain. The procedure followed at present is to send patients who are constantly in pain to the Washington VA Medical Center's pain clinic. It is my understanding that after a patient is released from that pain clinic it is often necessary to continue treatment using a therapeutic pool. However, none is available at this facility and, although one was in the budget for the present fiscal year, it was deleted, I was told, to save funds. And the saving was small, of the order of hundreds of dollars.

Therefore, with the average age of our veteran population increasing and with it the additional problems that come with aging, I feel that more thought and planning must be given to increasing the staff for outpatient care or the situation will assuredly grow worse. I would recommend reinstating the meal tickets for lunch and allotting sufficient funds for the purchase of a therapeutic pool for the treatment of chronic pain.

In conclusion, I must say that, given the present staffing and facilities, the quality of outpatient care provided here at Martinsburg is very good.

Gentlemen, thank you for your kind attention and for your continued interest in the welfare of this nation's veterans. Now Mr. Yurish would like to make a closing remark.

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